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HENRY W. ZARETSKY & Associates, Inc.

U.S. BANK PLAZA
980 NINTH STREET, 16TH FLOOR
SACRAMENTO, CALIFORNIA 95814-2736
(916) 447-2018

January 25, 1995

Mr. Phil Batchelor
County Administrator
Contra Costa County
County Administration Building
651 Pine Street, 11th Floor
Martinez, California 94553-1229

RE: Merrithew Memorial Hospital Replacement Study

Dear Mr. Batchelor:

Enclosed is my report, "An Assessment of Options Facing Contra Costa County Regarding Provision of Hospital Services," to be presented to the Board of Supervisors in its January 31 meeting.

I appreciate the opportunity of assisting the Board in dealing with this highly important and controversial issue, with far-reaching implications for the health care consumers and providers in Contra Costa County.

I look forward to meeting with you and the Board on January 31.

Sincerely,

Henry W. Zaretsky

Henry W. Zaretsky, Ph.D.

HWZ:cs

Enclosure

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980 NINTH STREET, 16TH FLOOR
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(916) 447-2018

AN ASSESSMENT OF OPTIONS FACING CONTRA COSTA COUNTY REGARDING PROVISION OF HOSPITAL SERVICES

Henry W. Zaretsky, Ph.D.

January 25, 1995

Prepared for presentation to the Contra Costa County Board of Supervisors on January 31, 1995.

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AN ASSESSMENT OF OPTIONS FACING CONTRA COSTA COUNTY REGARDING PROVISION OF HOSPITAL SERVICES

January 25, 1995

I. INTRODUCTION

The purpose of this report is to set forth an assessment of options available to Contra Costa County with regard to fulfilling its obligations to provide hospital care to its indigent population, and to recommend a specific approach for consideration by the Board of Supervisors. The guiding principle underlying the recommended approach is the assurance that indigent residents of Contra Costa County have access to needed, high quality hospital and emergency medical services provided in a fiscally-responsible manner.

Three specific options are examined:

(1) Proceed with the construction of the partial replacement of Merrithew Memorial Hospital, as envisaged in the Board action taken in 1992 which resulted in the issuance of certificates of participation in the amount of $125.6 million;

(2) Abandon the replacement project in favor of contracting with the three district hospitals located in Contra Costa County (Brookside Hospital District, Mt. Diablo Hospital District and Los Medanos Hospital District), operating under the guidance of a joint powers agreement. (The analysis of this option is based on a proposal submitted by the district hospitals on January 17, 1995); and

(3) County operation of the currently-closed Los Medanos Community Hospital, complemented by contracts with the two remaining district hospitals.

This report begins with a discussion of the complex problems facing the Contra Costa County Board of Supervisors as it considers which policy to pursue. Next is a discussion of the setting in terms of the health care environment in Contra Costa County, particularly with respect to indigent care. An analysis of each alternative is then presented. The report concludes with a recommended approach. The recommendation is two-fold: If the Board is compelled to take final action at this time, I recommend proceeding with the hospital replacement project. If, on the other hand, the Board could allow a brief period (e.g., 30

days) for the district hospitals to modify their proposal to substantially comply with the provisions set forth in the last section of this report, my recommendation would tilt in favor of the district hospitals' proposal, provided it in fact complies with these provisions. These recommendations are not being advanced as negotiating points. They are viewed as providing essential components of a system that would serve as a viable alternative to the hospital replacement project, in the best interests of indigent consumers and county taxpayers.

II. THE PROBLEM

If Contra Costa County is to continue to operate a county hospital, the current aging and seismically-unsafe facility will have to be replaced with a new facility. Moreover, such replacement will have to occur within a few years due to licensing requirements. In 1992, the Board of Supervisors approved construction of a replacement facility and the issuance of $125.6 million in certificates of participation to finance construction and acquisition of associated equipment. The project has been delayed due to a law suit filed by the NAACP Legal Defense and Educational Fund in 1993, claiming that the location of the facility discriminates against Blacks, Hispanics and Asians, denying them equal access to health services.

As a result of this delay, the County was approached, also in 1993, by the three hospital districts in Contra Costa County (Brookside, Los Medanos and Mt. Diablo) with a proposal to provide inpatient and emergency medical services to all county-responsibility patients (mainly the indigent population not qualifying for other public programs such as Medi-Cal and Medicare, and county jail inmates) under a contractual arrangement, as an alternative to construction of the county hospital replacement facility. This proposal is justified on the basis that it is a less costly and less risky alternative for the County to meet its indigent care obligation; given the current health care environment which is placing greater financial risk on hospitals, drastically reducing inpatient use, creating greater competitive pressures; and given uncertainty regarding the future availability of federal and state subsidies required to support a county hospital.

There are several important complications with respect to the latter scenario including, but not limited to, the following: First, one of the district hospitals (Los Medanos) has recently been forced to closed due to bankruptcy. Second, there is skepticism within segments of the community regarding the districts hospitals' ability and commitment to deliver. This is due to historical and recent financial problems at the hospitals; Brookside Hospital's cancelling of its Medi-Cal contract in 1992 (it has subsequently negotiated a new contract); perceptions that indigent patients are not welcome at Mt. Diablo Medical Center; and a variety of other problems, including the ability of the hospitals to serve special indigent populations, including AIDS patients, certain psychiatric patients and jail patients. Third, in order for this arrangement to be financially feasible for the County, payment rates for county-responsibility patients would have to be set below the hospitals' full costs, which may violate

State law. And fourth, integrating the County medical staff with the staffs of the district hospitals may be a complicated process.

The purpose of this report is to set forth an assessment of options available to Contra Costa County with regard to fulfilling its obligations to provide hospital care to its indigent population, and to recommend a specific approach for consideration by the Board of Supervisors. The guiding principle underlying the recommended approach is the assurance that indigent residents of Contra Costa County have access to needed, high quality hospital and emergency medical services provided in a fiscally-responsible manner.

Three specific options are examined:

(1) Proceed with the construction of the partial replacement of Merrithew Memorial Hospital, as envisaged in the Board action taken in 1992 which resulted in the issuance of certificates of participation in the amount of $125.6 million;

(2) Abandon the replacement project in favor of contracting with the three district hospitals located in Contra Costa County (Brookside Hospital District, Mt. Diablo Hospital District and Los Medanos Hospital District), operating under the guidance of a joint-powers agreement; and

(3) County operation of the currently-closed Los Medanos Community Hospital, complemented by contracts with the two remaining district hospitals.

III. THE SETTING

The county hospital, Merrithew Memorial Hospital (MMH), located in Martinez, with 174 licensed beds, cannot continue in operation due to its obsolete plant. While the hospital is located in the central part of Contra Costa County, the greatest concentrations of indigent populations are in the eastern and western regions. For example, of the County's 91,161 Medi-Cal eligible population (as of March 1994), 31 percent reside in the eastern region, 45 percent in the western region and 25 percent in the central region. The county hospital is thus complemented by a network of clinics distributed throughout the county.

The Contra Costa County health system has a national reputation as an innovator, largely due to its own health maintenance organization, the Contra Costa Health Plan (CCHP), which enrolls the county indigent population, Medi-Cal and Medicare beneficiaries, county employees and small employers. The county system also has a family practice residency program affiliated with the University of California at Davis. This program is viewed as responsible for placing a large number of its graduates throughout the community.

In 1992, the Board of Supervisors approved the issuance of $125.6 million in certificates of participation to finance a 144-bed partial replacement hospital, to be complemented by a contracting arrangement with Brookside Hospital for provision of inpatient and emergency care to a portion of medically-indigent west county residents. The replacement project is termed a partial replacement because of the reduction in licensed beds and increased reliance on contracting with Brookside Hospital.

In addition to MMH and the two currently operating district hospitals (Brookside and Mt. Diablo), Contra Costa County residents are served by two Kaiser hospitals (in Richmond and Martinez), Delta Memorial Hospital in Antioch, Doctors Hospital of Pinole, East Bay Hospital in Richmond (which is mainly psychiatric), John Muir Medical Center in Walnut Creek and San Ramon Regional Medical Center. The existence of three hospital districts with hospitals currently operating far below reasonable capacity-utilization levels (less than 40 percent occupancy at Brookside and Mt. Diablo [and zero occupancy at Los Medanos]), strategically located in the three regions of the county, and with semi-public sponsorship, adds an important dimension to the decision process regarding continued operation of a county-sponsored hospital.

While these district hospitals have previously not expressed serious interest in taking responsibility for all county-responsibility patients in addition to the bulk of Medi-Cal patients residing in the Contra Costa County, the combination of construction of the proposed replacement facility and low occupancy levels has prompted a reassessment. This reassessment has resulted in a serious proposal by the district hospitals to collectively take responsibility for the inpatient and emergency medical services portion of the county obligation to provide health care for unsponsored, indigent residents.[1]

These hospitals would fulfill the county obligation in a manner that would:

(1) Use the county-run clinics and medical staff;

(2) Maintain, and relocate, the family practice residency program;

(3) Use the CCHP as the contracting vehicle;

(4) Provide all inpatient and emergency services for an aggregate cost to the county not to exceed the current county subsidy of approximately $12 million annually, with annual adjustments for inflation and enrollment;

(5) Include a commitment to accept all county-sponsored patients regardless of diagnosis (e.g., AIDS, tuberculosis, psychiatric) or social status (e.g., jail, homeless); and presumably

(6) Better accommodate the geographic accessibility disparities, provide "seamless" care (i.e., better integrate indigent and private patients), and enable

the County to avoid the growing economic risks inherent in operating a hospital and meeting debt-service requirements.

The financial feasibility of the replacement hospital hinges on the continued availability of disproportionate-share hospital (DSH) funds mainly provided through two mechanisms -- SB 855 (significant supplemental Medi-Cal inpatient payments based on the volume of Medi-Cal patient days and the percentages of Medi-Cal and unsponsored patient days at Merrithew Memorial Hospital) and SB 1732 (Medi-Cal sharing in debt-service payments based on the percentage of Medi-Cal patient days). Should funds from both these sources continue to flow at current levels and should the replacement hospital maintain reasonable utilization levels (MMH, with occupancy rates in the mid-to-high 70 percent range, currently has the highest utilization level in Contra Costa County), debt service costs to the County would be minimal. Should these funds be reduced significantly, the County's risks increase markedly.

Along with this risk is the risk associated with operating a hospital in general, public or private. The general character of the "hospital" has changed significantly over the past decade, resulting in far less reliance on inpatient care. This is due to the increasing prevalence of managed-care programs and continued advancements in medical science that enable more and more services to be provided on an outpatient basis. At the same time, competitive forces have led to a major expansion in managed care market share, the "hospital" has been changing in character. Today's hospital is far less reliant on inpatient volume than in the past. Besides hospitals and groups of hospitals becoming vertically-integrated health systems, within their own four walls hospitals have experienced a marked increase in outpatient activity, at the expense of inpatient activity. While in 1982, 15 percent of hospital gross charges in California represented outpatient activity, by 1991 this had grown to 22 percent, a 45 percent increase. Patient days per 1,000 population dropped 35.2 percent over this period, from 682 to 442.[2]

Outpatient visits have increased 48 percent over this period, while patient days have decreased 20 percent. In 1982, 19 percent of hospital surgeries were performed on an outpatient basis. By 1991, this had more than doubled, to 47 percent.[3] And this excludes the growing number of surgeries performed in free-standing surgery centers and in physicians' offices.

At the national level, from 1984 to 1991 the proportion of hospitals with organized outpatient departments grew from 50 percent to 87 percent. Between 1980 and 1990, hospital outpatient revenue increased from $11 billion to $63 billion. While in 1983 12.5 percent of hospital revenue was attributed to outpatient volume, by 1990 it represented 25.4 percent. These increases are mainly attributed to greater volume and greater complexity of outpatient services provided.[4]

Managed care plans have experienced rapid growth in market penetration locally and nationally. Nationally, health maintenance organization (HMO) market penetration increased

from 4 percent in 1980, to 14.6 percent in 1990 (an enrollment increase from 9.1 million, to 36.5 million).[5] While comparable data on preferred provider organizations (PPOs) are not available, it is estimated that by 1990, 33 percent of all insured employees were enrolled in either HMOs or PPOs.[6] By 1993, HMO enrollment reached 46.7 million, 18.5 percent of the entire U.S. population.[7]

Clearly, managed care is likely to be the predominant method of health care delivery in the future. In many parts of the U.S., it already is. For example, in 1989 the San Francisco-San Jose-Sacramento metropolitan areas had a 46 percent HMO penetration rate, and the Minneapolis area a 44 percent rate.[8] For California as a whole, in 1993 HMO penetration was 36 percent of the entire population, up from 30.6 percent in 1991, and 17 percent a decade earlier.[9] Anecdotially, it has been reported that in Contra Costa County, approximately 90 percent of privately-insured residents are enrolled in managed-care plans.

Thus, in deciding to continue as a hospital provider, Contra Costa County has to consider the twin risks inherent in dependence on DSH funds, and in running any kind of hospital in an era of growing competitive pressure and declining inpatient use. Against these risks must be weighed the equally important risks facing the would-be contracting hospitals operating in this competitive environment. Should even one of them fail, county-responsibility and other indigent patients could be placed at great risk, and the Board of Supervisors would have to devise a potentially-high-cost mechanism to fulfill the county obligation.

IV. EVALUATION OF ALTERNATIVES

Overall Objective

In assessing the alternatives available to Contra Costa County, I was guided by the objective of maintaining access to needed, high quality health services on the part of the County's indigent population (the county-responsibility population as well as Medi-Cal and Medicare beneficiaries who have difficulty receiving care in the private sector), provided in a manner at least as culturally sensitive and dignified as in the current county health system, and affording the County necessary predictability and control over its health services budget. Other objectives include the ability of Contra Costa County to maintain its innovative role in health care through maintaining, and expanding, its health plan and maintaining its family practice residency program, which has become increasingly important to the entire County population as managed care expands in a health system currently unbalanced in favor of medical specialists.

Alternatives

1. Partial Replacement Project

Pursuing the partial replacement of Merrithew Memorial Hospital would involve the following advantages and disadvantages:

(1) It would place the County in the "driver's seat" regarding the ability to contract with other hospitals for services at reasonable payment rates. Once the replacement project is abandoned, the relative negotiating strength shifts to the potential contracting hospitals, who could be in a position to demand higher payment rates. It should be noted that in 1992 both Brookside and Los Medanos cancelled their Medi-Cal contracts in an effort to increase their payment rates;

(2) It would preserve the status quo regarding indigent access to services, in addition to providing such access in greatly improved facilities;

(3) It would enable the continued flow of DSH funds to the extent they are available statewide. With the closing of MMH, the bulk of the $10 million to $13 million in DSH funds would be diverted away from Contra Costa County, although it is likely that Brookside Hospital could eventually recover a portion of these funds. In addition, all the SB 1732 (Medi-Cal debt-service assistance) funds would be lost (approximately $5.1 million annually should the project proceed). Total annual debt service payments for the replacement hospital will be approximately $9.9 million, with $5.1 expected from SB 1732 subsidies, $1.3 million from Medicare capital reimbursement and $3.5 million set aside from DSH payments, resulting in no county general fund expenditures;

(4) If the DSH funds continue at current levels and the new facility is well utilized, the County General Fund should not be placed at significant risk for debt service requirements;

(5) The new facility is likely to be the only fully seismically safe facility available to indigent patients. As a result of the Northridge earthquake, new requirements will be placed on hospitals to meet seismic safety standards through SB 1953 (Alquist), which was enacted in 1994. By 2008, all hazardous structures (i.e., generally pre-1960 buildings) will no longer be able to be used for hospital inpatients. By 2030, all hospitals treating inpatients will be required to at least meet 1973 building standards. Hospitals using pre-1960 buildings for inpatient care will, within the next few years, be required to make decisions regarding partial, or full, closure or new construction. For some vulnerable hospitals, this will result in closure by 2008, if not before.

Brookside Hospital, whose major inpatient facility was constructed prior to 1960, will be particularly vulnerable, and will most likely be required to undertake major construction prior to 2008;

(6) The replacement plan envisages expanded contracting with Brookside Hospital, which would improve access for West County residents. Given the need, however, to fully utilize the new hospital, there may have to be some restrictions on diversion of potential Merrithew patients to Brookside;

(7) The replacement hospital, due to financial constraints, will not be self contained. In particular, psychiatric services are to be provided in a wing of the current facility (which is apparently seismically safe);

(8) While the replacement facility will be centrally located, it will not be located where the indigent populations are most concentrated (West and East County). Thus, geographic proximity to inpatient services will not improve for indigent residents of these areas, other than with respect to the limited contracting with Brookside discussed above;

(9) Given the considerable and continuing movement away from inpatient acute care, there are no guarantees the new facility will be utilized to the extent required for efficient operation. Moreover, implementation of Medi-Cal managed care, scheduled to commence in 1996, should result in reduced overall inpatient use by the Medi-Cal population, in addition to increased competition from other hospitals for Medi-Cal business as the Local Initiative (the county-organized health plan) competes with a commercial plan for capitated Medi-Cal enrollees. These potential threats to inpatient use at the new hospital should be considered in light of expected population growth in Contra Costa County, from 818,300 in 1990 to 1,212,800 by 2020, a 50 percent increase.[10] The share of this projected population growth represented by indigents, however, is not known;

(10) The project's dependence on the continued availability of DSH funds at approximately current levels is a major concern. With, or without, a new hospital, continuing as a county-hospital provider would not be economically viable without access to such subsidies. Continuation of the SB 855 program of substantial payment supplements for disproportionate-share Medi-Cal hospitals is far from assured. This program accounts for approximately $1.1 billion in federal Medicaid funds flowing to California annually. Of this, the State Department of Health Services receives over $250 million to partially support its administrative functions. Should this source of revenue be significantly curtailed without replacement from another source, all counties operating hospitals (in addition to the State of California) will be placed in severe jeopardy, to the extent that a major reduction would not be politically

feasible. If there are aggregate reductions, they are likely to be complemented by a shifting of the remaining funds away from private disproportionate-share hospitals, to county hospitals through greater weight being given to outpatient services and to services provided to unsponsored patients.

While the availability of DSH funds is essential to running a county hospital in general (new or old), the most important source of funds earmarked for debt service is through SB 1732. These debt-service-specific subsidies account for approximately half the projected debt service payments. These funds should be more secure than the SB 855 funds since this is a closed-end program. To be eligible for such funds, eligible disproportionate-share hospitals were required to submit final construction plans to the Office of Statewide Health Planning and Development (OSHPD) by June 30, 1994. In addition, projects under this program on behalf of several major county hospital replacements are either planned or in progress, and bonds have been issued under the expectation of availability of this source of funds. Reneging on this obligation by future governors and legislatures is highly unlikely. Unless universal coverage is implemented at the national level, which appears unlikely for the foreseeable future, disproportionate-share funding is expected to continue.

Table 1 is an attempt to show the impact on the county subsidy for inpatient and emergency care for three alternative levels of SB 855 funding cuts -- 100 percent, 50 percent and 25 percent. The County during the 1993-94 fiscal year received $13.4 million through both SB 855 ($12.7 million) and SB 1255 ($0.8 million). (The latter subsidy is obtained through negotiations with the California Medical Assistance Commission [CMAC], rather than through a formula.) Of these funds, $3.5 million has been set aside for the past two years, as this amount is earmarked by the County to be dedicated to annual debt service payments. The 1993-94 county subsidy was $11.8 million. If these DSH funds are lost altogether and the project is implemented, the county subsidy rises from $11.8 million to $25.2 million. A 50 percent reduction pushes the subsidy to $18.5 million, while a 25 percent reduction pushes it to $15.1 million. While there is a high degree of uncertainty regarding what, if any, reduction is likely, the 0 to 25 percent range appears more likely than a higher range. Under this scenario, the county subsidy could increase from the current $11.8 million to $15.1 million;

(11) No major counties in California without a University of California (UC) hospital have closed their county hospitals. Major counties with UC hospitals that no longer operate county hospitals (Sacramento, Orange and San Diego), converted their hospitals to UC hospitals and then contracted with those hospitals for indigent care; and

(12) Moving ahead with the replacement project would enable the maintenance of the family practice residency program without disruption.

2. Contracting with the District Hospitals

This scenario offers the potential for the following advantages and disadvantages:

(1) If the district hospitals support the reopening of Los Medanos and bring that hospital into the network (Mt. Diablo indicated an interest in doing so), access to inpatient services for East County indigent residents will be improved, in that they will not be required to travel to Martinez, or Concord in the case of only two participating district hospitals. In both cases (two-or three-hospital network), access for West County residents is improved;

(2) Since the district hospitals are semi-public, there may be more accountability to the public than is the case with private for-profit or not-for-profit hospitals. Moreover, this opens the possibility of a joint powers agreement (JPA) between the county and the districts, which could enable cost-effective operation as an integrated system;

(3) If the county obligation is capped at the current level (with annual adjustments for economy-wide inflation and enrollment changes), county funds are protected and the risk of operating a hospital is avoided. On the other hand, while the county will avoid this risk, the district hospitals obviously will not. Should one or more of the district hospitals run into economic problems, county taxpayers may be vulnerable;

(4) If the County maintains its network of clinics and the county-employed and contracted medical staff is fully integrated into the district hospitals' medical staffs, indigent access would be maintained and the ability to provide culturally-sensitive care to indigent groups would remain intact;

(5) The viability of this approach requires the continuation of the family practice residency program. Splitting the program among multiple sites could cause problems, as could conflicts between the training program and specialty physicians, especially at Mt. Diablo. Family practice residents must be given exposure to specialty practice. The Merrithew Residency Program Director believes that under the district hospitals' proposal, the program is unlikely to survive, and if it does its costs would increase;[11]

(6) This approach should enable continued operation of the Contra Costa Health Plan, and could, under an integrated delivery system operating under a JPA, enable further expansion of the CCHP into the commercial and Medicare markets;

(7) Psychiatric inpatient services could become more community based, through use of the Mt. Diablo Behavioral Medicine Pavilion and a subcontract with East Bay Hospital in Richmond;

(8) The ability of the district hospitals to gain substantial volume from accommodating former Merrithew patients will enable more efficient use of existing capacity, and thus enable the hospitals to contract with the County on a marginal cost basis. This would be the only way, if any, the district hospitals could assume the entire inpatient and emergency services obligation at the current county subsidy level with the loss of $13.4 million in DSH funds. There is not sufficient information in the district hospitals' proposal to determine its long-run financial feasibility.

In an attempt to better understand this issue, Table 2 calculates the added revenue to the district hospitals assuming they recover all of Merrithew's net revenue (county subsidy, Medi-Cal, Medicare, self-pay and commercial), excluding DSH payments, which will not be available. The table shows that they could gain $54.5 million in net revenue ($42.7 million from the health care payers and $11.8 million from the county subsidy). This assumes the district hospitals on average receive the same payment rates as Merrithew from the various payers. (This is doubtful with respect to Medi-Cal and Medicare.) The cost to the county of providing these services was $65.8 million. For inpatient services only, average cost per patient day was $1,172, compared to net revenue (excluding DSH payments), plus the county subsidy, of $933 per patient day. Thus, under this scenario, marginal cost per patient day for the district hospitals could not exceed $933 (including inpatient physician costs for county indigent patients and Medi-Cal payment shortfalls for physicians). If marginal costs exceed this level, the proposal is not economically viable. As indicated above, the County is currently setting aside $3.5 million annually for future debt service payments. Thus, a case could be made that the "true" county subsidy is $8.3 million ($11.8 million - $3.5 million). Under this assumption, added revenue to the hospitals would fall to $50.1 million, $857 per patient day on an inpatient basis (again, including physician costs for county patients and Medi-Cal payment shortfalls for physicians).

Table 3 provides an equivalent analysis, under the assumption that the district hospitals would receive lower inpatient payments (from primarily Medi-Cal and Medicare), which would average 20 percent below aggregate payment rates received by Merrithew. Under this scenario, the hospitals' marginal inpatient costs could not exceed $775 per patient day, assuming the $11.8 million subsidy, or $699 assuming the $8.3 million subsidy.

While there is no doubt that filling excess beds with former Merrithew patients should result in lower costs in the aggregate, the matching of these

costs with added revenue flowing to the district hospitals is not clear in the current proposal;

(9) Given the current patient population at Mt. Diablo, an infusion of indigent patients (including homeless, jail and AIDS) could result in cultural shock, especially if Los Medanos is not part of the network. Table 4 projects the increase in only AIDS patients, based on the current distribution of these patients among hospitals and county-wide projections to 2000. Note that if Los Medanos is not included, AIDS patients at Mt. Diablo would increase from one per day to over five (a five-fold increase). With Los Medanos included, the increase would be from one to three;

(10) Besides the financial issues raised in (8) above, the arrangement may not be financially feasible if Mt. Diablo is more specialty oriented than Merrithew (for a given mix of diagnoses). The Merrithew medical staff is 70 percent primary care and 30 percent specialty, the opposite of most private hospital medical staffs. A related financial issue involves Merrithew's payment of Medi-Cal physician payment shortfalls (i.e., the difference between the physician's salary and Medi-Cal receipts). The district hospitals will be responsible for this component for inpatient professional services provide by county-employed physicians. Finally, charity costs at Brookside and Mt. Diablo totaled $2.6 million in the 1994 fiscal year. If such costs are transferred to the "county indigent patient account" through annual enrollment adjustments, county costs would increase by this amount. (This is analogous to providing publically-funded school vouchers to parents with children already in private schools.);

(11) Some aspects of the district hospitals' historical track record is not encouraging, raising doubts regarding their ability to follow through. This includes previous management at all three facilities;

(12) The annual loss of $10 million to $13 million in DSH funds and $5.1 million in Medi-Cal debt service subsidies largely represents a dead weight loss to the County's entire health system and economy (although a portion of the DSH payments could flow to Brookside);

(13) Defeasance costs on the $125.6 million certificates of participation are estimated at approximately $25 million. This is built into the district hospitals' proposal. But, as with the DSH and debt-service subsidies, these costs represent a loss to the local health system and economy;

(14) If the arrangement fails after the replacement project is abandoned, Contra Costa County will have no alternative but to contract with whatever hospitals are willing to do so, at their dictated price. There will be no way to

recoup the lost SB 1732 debt service subsidies, and thus no way to resurrect the replacement project. This could be a political and economic catastrophe. Given Los Medanos' current, and Brookside's immediate past, financial difficulties and given a potential major change in the composition of patients at Mt. Diablo, this worst-case scenario is not that unlikely;

(15) More efficient use of existing resources necessarily entails reduced overall staffing levels. Even if the added jobs at the district hospitals are filled only with displaced Merrithew employees, which the district hospitals have not committed to, there are bound to be job losses among county employees and associated law suits. Since the added employment opportunities at the district hospitals would derive solely from Merrithew's closure, Merrithew employees should be given the first opportunity to fill these jobs;

(16) The inevitable seismic-safety issue with respect to at least Brookside Hospital was discussed above. County tax payers could end up subsidizing construction of a replacement hospital for Brookside; and

(17) Finally, Section 32125 (b) of the Health and Safety Code prohibits a district hospital from contracting to care for indigent county patients at below the cost of care. If this section is not interpreted in terms of marginal costs, the proposal is not feasible. A scenario where a disgruntled district resident (unhappy with the environmental impact of the new patient mix, for example) files suit against the district on the basis of this section is entirely feasible. It is also not unlikely that a future district board would demand a substantial payment increase from the County based on this provision.

3. Use of Los Medanos as the County Hospital

This does not appear to be a practical substitute for the Merrithew replacement project or for the arrangement with the district hospitals for the following reasons:

(1) Given its location and size, it would have to be supplemented with contracts with other hospitals for most of the current Merrithew volume. The County would thus remain in the hospital business with its associated risks, would not be eligible for the SB 1732 debt-service subsidies and, under current law, the issued certificates of participation could not be used to fund this acquisition;

(2) Contracting for only a portion of the former Merrithew patient volume would not be as attractive to the two remaining district hospitals, especially Mt. Diablo, and thus these hospitals would demand higher payment levels;

(3) With less Medi-Cal volume than currently occurring at Merrithew, DSH

payments would be reduced, adding to the current county subsidy. As indicated above, SB 1732 subsidies would not be available for acquisition or lease payments;

(4) The district's bankruptcy receiver is requesting a $25 million purchase price, which is most likely negotiable; and

(5) The outstanding debt incurred by Los Medanos is approximately $18.5 million, with bond proceeds of $5.5 unspent. The district receives local tax revenue of approximately $1.6 million annually. Should the hospital be converted to a county hospital, it is doubtful the district's voters would allow the district's taxing authority to remain. It appears preferable for the hospital to reopen as a district hospital, and thus be integrated in the district hospital network under consideration.

V. RECOMMENDATION

While the proposal presented by the district hospitals has substantial potential, it requires significant elaboration, modification and strengthening. If the Board is compelled to act based solely on currently available information, my recommendation is to authorize proceeding with the Merrithew replacement project. If, on the other hand, the Board could allow a brief period (e.g., 30 days) for the district hospitals to modify their proposal to substantially comply with the provisions set forth below, my recommendation would tilt in favor of the district hospitals' proposal, provided it in fact complies with these provisions. These recommendations are not being advanced as negotiating points. From my perspective, the only viable alternative to the hospital replacement project is the structure set forth below.

The arrangement with the district hospitals should be structured as follows:

(1) Los Medanos Hospital be reopened and become part of a three-district-hospital network;

(2) A Joint Powers Authority be created to govern the three-hospital system, the county clinics and the Contra County Health Plan. The JPA governing body should have equal representation from each of the hospitals and the County. This JPA will enable the creation of an integrated health system comprised of three hospitals, the county clinics and the Contra Costa Health Plan, which would become a mixed staff-model-IPA-model HMO. Governance by the JPA necessarily entails placing all three districts under one governing body. Given that the three hospitals are generally non-competing, their consolidation could only strengthen them collectively. Resistance by the individual district boards should evaporate once the benefits of such

consolidation become apparent in this era of cut-throat competition, excess hospital capacity and vertical and horizontal integration. Without a county hospital, the County has a vital interest in the economic viability of the health delivery system on which it depends, and this form of governance appears to be the best mechanism to foster economic viability. The JPA should be established and become operational within six months.

A less effective, although less controversial, arrangement would entail limiting the JPA's authority to planning, monitoring and coordinating the delivery of health services by network providers (i.e., the three hospitals and the county clinics) to the indigent population, including county-responsibility patients as well as Medi-Cal and indigent Medicare patients. Given the limited scope of this governing authority, the County should be entitled to at least half the votes on the governing body. A JPA with this narrow a scope will be less effective in creating an economically viable, competitive, integrated health system. While a minimal requirement for dealing with indigent health care delivery, it misses the mark in terms of recognizing that cost-effective provision of health services cannot be accomplished on a payer-specific basis. It must involve all classes of purchaser. Over the long run, providing services to county patients through cost shifting to other payers is not a viable option, especially if the system is not competitive in the private market. Thus, the limited JPA is not recommended. Establishment of this limited-authority JPA should take no more than 60 days;

(3) The JPA should be advised by a Consumer Advisory Council (CAC), representing the indigent population;

(4) The governing body and the CAC should jointly hold monthly public meetings, alternating among the three regions within the County. These meetings should encourage public participation and should focus on the provision of care to indigent consumers in terms of quality, waiting time, appropriateness of care and cultural sensitivity. All identified deficiencies should be thoroughly investigated and the findings and plan of correction announced in public meetings. Progress on the plan of correction should be monitored and reported back to the public. This process should include employment of a patient ombudsman at each hospital and periodic patient surveys;

(5) All hospitals should be obligated to a 30 year contract, with severe financial penalties for cancellation;

(6) All services to county-responsibility patients should be provided within an aggregate expenditure limit approximating the current county subsidy for inpatient and emergency medical services. Within this limit, the hospitals

should recognize their responsibility to reimburse the County for inpatient services provided by county-employed physicians at levels comparable to their salaries (i.e., Medi-Cal payment shortfalls will be a hospital responsibility);

(7) The aggregate expenditure limit should be adjusted annually for economy-wide inflation and changes in enrollment. The inflation adjuster should be based on the Hospital Market Basket Index, which serves as a basis for Medicare prospective payment adjustments. This index is designed to measure specific inflationary pressures on hospitals, as opposed to the Consumer Price Index, which measures retail price changes affecting consumers;

(8) Just as the County would have a maintenance of effort requirement regarding the base-line subsidy, with annual adjustments, so should the hospitals have a maintenance of effort requirement regarding provision of unreimbursed charity care. Mt. Diablo and Brookside, during the 1994 fiscal year, collectively provided approximately $2.6 million in charity care, on a cost basis. These expenditures should not be shifted to the county taxpayers through the enrollment adjustment process;

(9) The hospitals should be required to accept all patients who would have been treated at Merrithew, including AIDS, detention, homeless, substance-abuse, tuberculosis and psychiatric patients. Psychiatric patients should be treated on the Mt. Diablo campus, and unless, or until, Brookside develops an inpatient psychiatric program, adequate capacity should be obtained from East Bay Hospital through a subcontract with Brookside;

(10) The family practice residency program should be maintained, headquartered at one location and administered by the current leadership. There are serious doubts whether it will be feasible under the proposed arrangement to maintain the program. These doubts concern potential decentralization, lack of experience in the district hospitals and possible incompatibility of medical practice patterns at the district hospitals and requirements for an effective family practice training program. This is a highly valuable program for the entire health care community and its continuation should be assured;

(11) Merrithew Memorial Hospital medical staff should be fully integrated into the staffs of the appropriate district hospitals, with privileges consistent with those held at Merrithew. Given Merrithew's reputation for high quality care, such integration should not be a problem. Thus, should credentialling problems occur, the most likely cause will be "turf" conflicts, not medical competence. These conflicts should not be tolerated. At least for some interim period, Merrithew staff should remain as county-employed, salaried physicians,

with hospitals reimbursing the County for their services at agreed-upon rates, consistent with current expenditures. If, and when, under the comprehensive JPA model, health care is provided in a seamless manner to public and private patients, other arrangements could be considered (e.g., employed by Contra Costa Health Plan or another group);

(12) Current Merrithew Memorial Hospital employees should remain employees of the County and be dispatched to the district hospitals as appropriate. Health care effectiveness dictates that the personnel most able to care for the Merrithew patient population should be utilized to the maximum extent feasible. Fairness dictates that since the surge in volume to occur at the district hospitals, and associated employment opportunities, derives solely from closing Merrithew, all staffing increases at the district hospitals should come from the Merrithew pool. Maintaining these employees' county-employed status, at least during a reasonable transition period, will minimize conflicts involving pensions and fringe benefits. The district hospitals would contract with the County for employee services. Moreover, this arrangement should enable the district hospitals to increase staffing without offering first rights of refusal to their former employees. Since the proposed network, by more fully utilizing excess capacity at the district hospitals, should result in a less costly system, total employment (i.e., present employment levels at Merrithew and the three district hospitals) may shrink. This could be ameliorated by the districts' offering early retirement incentives to their current employees and the reopening of Los Medanos. With respect to the latter, the bulk, if not all, of the restaffing should be obtained from the Merrithew pool. Again, the only realistic hope of Los Medanos reopening as an acute facility comes from the closure of Merrithew;

(13) The district hospitals should immediately collectively absolve the County of its defeasance obligation of approximately $25 million. While the current proposal from the district hospital deals with this issue on an annual basis in the context of a reduction in annual reimbursement, should the program fail, the County will be responsible for the outstanding balance of the defeasance costs. Under this recommendation, should the program fail prior to the defeasance obligation being fully retired, the district hospitals would be required to fully defease the obligation;

(14) The district hospitals should collectively establish and fund a "Seismic Safety Construction Account" to assure that all facilities will comply with all state seismic-safety codes through the year 2025. This account will be funded by annual contributions of at least $2 million by the district hospitals. If necessary, the debt incurred in financing construction to meet seismic safety codes will be secured by the hospitals on a collective basis. Should required construction or facility acquisition not proceed and an essential facility be

forced to close (e.g., Brookside Hospital), all proceeds in the fund will revert to the County. The district hospitals, through the JPA, should develop, and periodically update, a seismic safety construction and acquisition plan, prioritized in terms of the most vulnerable facilities. The probability of at least Brookside Hospital being required to undertake a costly construction project prior to 2008 is high (a virtual certainty). Should such construction not proceed, the County will be left with a major hole in its delivery system and could be pressured to partially finance needed construction, above and beyond its annual expenditure. Thus, such a fund is necessary, along with significant sanctions for noncompliance; and

(15) To preserve and enhance the Contra Costa Health Plan, that plan should be granted "most favored nation" status with respect to all managed-care contracts negotiated by the district hospitals. The "most favored nation" provision should guarantee the CCHP the lowest price received by each district hospital according to business line (i.e., Medi-Cal, Medicare, commercial and Workers' Compensation), regardless of volume.

END NOTES

1. "Joint Hospital District Proposal to: Contra Costa County Board of Supervisors," January 17, 1995.

2. Annual Hospital Financial Disclosure Reports, Office of Statewide Health Planning and Development, hospital fiscal periods ending between June 30, 1982 and June 29, 1983, and between June 30, 1991 and June 29, 1992.

3. Ibid.

4. Prospective Payment Assessment Commission, Medicare and the American Health System: Report to Congress, Chicago: Commerce Clearing House, June 1993, 91-92.

5. M.R. Gold, "HMOs and Managed Care," Health Affairs, 10:4 (Winter 1991), pp. 189-219.

6. op. cit.

7. Marion Merrell Dow Managed Care Digest, 1993.

8. Gold, op. cit.

9. Marion Merrell Dow, op. cit.

10. Population Projections by Race/Ethnicity for California and its Counties 1990-2040, Department of Finance, April 1993.

11. Letter from T. Rich McNabb, M.D., January 23, 1995.

TABLES

Projected Impact of Reduction of Disproportionate-Share Funds

If DSH re SB 855 and SB 1255 are zero and SB 1732 remains

Subsidy before bldg	$21,700,434
Capital	$3,500,000
Medicare shortfall	
Total subsidy	$25,200,434

If DSH drops by 1/2

Subsidy before bldg	$16,730,252
Capital	$1,750,000
Medicare shortfall	
Total subsidy	$18,480,252

If DSH drops by 1/4

Subsidy before bldg	$14,245,160
Capital	$875,000
Medicare shortfall	
Total subsidy	$15,120,160

TABLE 1

Based on 1993-94 Volume and Subsidies

Incremental Revenue to District Hospitals

	Total	Inpatient	Per PD
Net Rev Less DSH	$42,730,758	$36,374,974	$789
County Subsidy	$11,760,069	$6,639,739	$144
Marginal Revenue to Districts	$54,490,827	$43,014,713	$933
Total Cost to County	$65,782,595	$54,049,800	$1,172
Net DSH	$13,440,365	$13,440,365	$292
Non oper	$1,351,403	$1,094,722	$24
Subsidy	$11,760,069	$6,639,739	$144
Set Aside	$3,500,000	$3,500,000	$76
Net Subsidy	$8,260,069	$3,139,739	$68
Marg. Rev Less $3.5M	$50,990,827	$39,514,713	$857

TABLE 2

Based on 1993-94 Volume and Subsidies

Incremental Revenue to District Hospitals

	Total	Inpatient	Per PD
Net Rev Less DSH	$42,730,758	$36,374,974	$789
Less 20% Inpatient	$35,455,763	$29,099,979	$631
County Subsidy	$11,760,069	$6,639,739	$144
Marginal Revenue to Districts	$47,215,832	$35,739,718	$775
Total Cost to County	$65,782,595	$54,049,800	$1,172
Net DSH	$13,440,365	$13,440,365	$292
Non oper	$1,351,403	$1,094,722	$24
Subsidy	$11,760,069	$6,639,739	$144
Set Aside	$3,500,000	$3,500,000	$76
Net Subsidy	$8,260,069	$3,139,739	$68
Marg. Rev Less $3.5M	$43,715,832	$32,239,718	$699

TABLE 3

Based on 1993-94 Volume and Subsidies

Projected AIDS Patient Days at District Hospitals

AIDS Days	1992	2000	Change	Without Merrithew and Los Medanos			
				Total	Change	Tot ADC	Chng ADC
Los Med	115	205	90	0	-115		-0.32
Mt. D.	268	616	348	1923.5	1655.5	5.27	4.54
Brookside	329	628	299	1935.5	1606.5	5.30	4.40
Merrithew	1121	2410	1289	0	-1121		-3.07
All Other	942	2181	1239	2181	1239	5.98	3.39
Total	2775	6040	3265	6040	3265	16.55	8.95

AIDS Days	1992	2000	Change	Without Merrithew			
				Total	Change	Tot ADC	Chng ADC
Los Med	115	205	90	1008.33	893.33		-0.32
Mt. D.	268	616	348	1419.33	1151.33	3.89	3.15
Brookside	329	628	299	1431.33	1102.33	3.92	3.02
Merrithew	1121	2410	1289	0.00	-1121.00		-3.07
All Other	942	2181	1239	2181.00	1239.00	5.98	3.39
Total	2775	6040	3265	6040	3265	16.55	8.95

TABLE 4

Based on August 16, 1994 Memo from Wendel Brunner, MD